STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88707-001**
v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 12th day of May 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 25, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The initial request was incomplete. After additional information was provided, the Commissioner reviewed the request and accepted it on April 15, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 23, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). Rider CBD $1000-P (Community Blue Deductible Requirement For Panel Services), Rider CBC 20%-P (Community Blue Copayment Requirement 20% For Panel Services), and Rider CB-CM-P $1500 (Community Blue Co-payment Maximum For Panel Services) also apply. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On June 13, 2007, the Petitioner underwent an outpatient MRI at XXXXX. The hospital charges amounted to $1,131.50. BCBSM's approved amount for the service was $945.26. BCBSM applied $901.29 of the approved amount to the Petitioner's deductible and $8.79 to her copayment (a total of $910.08). BCBSM then paid the $35.18 balance.

The Petitioner appealed BCBSM's decision to apply $910.08 to the deductible and copayment. BCBSM held a managerial-level conference on January 10, 2008, and issued a final adverse determination dated January 15, 2008.

III
ISSUE

Did BCBSM correctly process the Petitioner's claims for the MRI provided on June 13, 2007?

IV
ANALYSIS

Petitioner's Argument

In December 2005 the Petitioner had an MRI at XXXXX that was covered in full. Later she required another MRI. She says she called BCBSM to be sure that if she went to XXXXX the MRI would be covered in full. She wanted to use XXXXX since it was closer to her work. However, she says she would have been happy to use XXXXX again if it were less costly for her. The Petitioner asserts that she was told in a telephone call with a BCBSM customer service representative that the MRI at XXXXX would be covered in full with no out-of-pocket expense.

The Petitioner says that it was only after she had the MRI that BCBSM told her that the deductible and copayment would apply. She requests that BCBSM be required to reimburse the full approved amount for her June 13, 2007, MRI at XXXXX. She believes this is fair since BCBSM misled her to believe there would be no deductible or copayment for this service.

BCBSM's Argument

BCBSM says it correctly paid for the MRI the Petitioner received on June 13, 2007, according to the terms and conditions of the certificate. First, Rider CBD $1000-P specifically provides that:

> You [the Petitioner] are required to pay the following deductible each calendar for most covered services provided by panel providers:
>
> - $1,000 for one member

The Petitioner is not required to pay the deductible for services performed in a panel physician's office. However, the MRI in June 2007 was performed in a hospital outpatient setting so BCBSM says the deductible applies. BCBSM applied $901.29 of its approved amount of $945.26 to complete the Petitioner's $1,000.00 deductible for the year 2007.

Next, Rider CBC 20%-P requires a 20% copayment for panel serves. In this case, the copayment is computed after the deductible is subtracted from the approved amount ($945.26 - $901.29 = $43.97). The copayment is 20% of $43.97 or $8.79. BCBSM then paid the balance, $35.18, to the provider.

BCBSM reviewed its records and says it can find no telephone calls from the Petitioner around the time of the MRI in June 2007. There was a call on February 23, 2007, but BCBSM's records indicate the Petitioner was told in that call that a referral is not needed if the provider participates with PPO. BCBSM also says the provider's office called on February 22, 2007, and was advised that a deductible and copayment would apply for an outpatient visit. Therefore, BCBSM contends it did not misinform the Petitioner about her benefits.

BCBSM believes that it paid the proper amount under the certificate language and is not required to pay any additional amount.

Commissioner's Review

The Petitioner said that her 2005 MRI at XXXXX was paid in full and she does not understand why the same service at XXXXX required a deductible and copayment. It is not entirely clear why the MRI at XXXXX was paid differently. However, both Riders CBD $1000-P and CBC

20%-P indicate that panel services provided in a panel doctor's office are not subject to the panel deductible and copayment. Therefore, if XXXXX is considered a doctor's office, no deductible and copayment would be applied. What is clear is that the Petitioner's MRI at XXXXX was subject to the panel deductible and copayment and was paid under the terms of the Petitioner's certificate.

The certificate explains that the Petitioner is required to meet a $1,000.00 deductible and a 20% copayment for most covered services from providers in BCBSM's PPO panel. In this case, XXXXX is a panel provider and is required to accept BCBSM's approved amount of $945.26 as payment in full for the Petitioner's June 13, 2007 MRI. After applying $901.29 to the Petitioner's panel services deductible and applying the 20% panel copayment, BCBSM paid $35.18 to the provider. None of the exceptions to the deductible requirement in Rider CBD $1000-P apply in this case. The Commissioner finds that BCBSM processed the benefits for the Petitioner's MRI correctly according to the terms and provisions of the certificate and its riders.

The Petitioner does not really find fault with BCBSM's application of the terms of the certificate to the service in this case. Her principal complaint is that she was given misinformation by BCBSM and, by acting in reliance on that information, incurred considerable out-of-pocket costs that she could have avoided. BCBSM disputes her contention, saying that it could find no records of telephone calls where incorrect information was conveyed. This kind of dispute cannot be resolved in a review under the Patient's Right to Independent Review Act (PRIRA).

Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. Resolution of a factual dispute like the one described by the Petitioner cannot be the basis of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements and witness credibility. Moreover, the Commissioner lacks the authority under PRIRA (which the circuit courts possess) to order equitable relief based on doctrines such as estoppel or waiver.

In conclusion, the Commissioner finds that BCBSM has correctly applied the provisions of

the Petitioner's certificate and applicable riders.

V
ORDER

BCBSM's final adverse determination of January 15, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's June 13, 2007, MRI.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Ken Ross
Commissioner